

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2010
FORM APPROVED
OMB NO. 0938-0391

45th 12/2/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
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NAME OF PROVIDER OR SUPPLIER

BRIARCLIFF HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

100 ELMHURST DR
OAK RIDGE, TN 37830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to update the care plan to include fall prevention measures for one resident (#6) of twenty-four residents reviewed.</p> <p>The findings included: Resident #6 was admitted to the facility on August 3, 2009, with diagnoses including Paranoid Schizophrenia, Multiple Sclerosis, and Gastrostomy.</p> <p>Medical record review of the MDS (Minimum Data</p>	F 279	<p>This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal law, and not because Briarcliff Healthcare Facility agrees with allegation(s) and citation(s) listed on this Statement of Deficiencies. Briarcliff Healthcare Facility maintains that the alleged deficiencies do not individually or collectively constitute substandard care or jeopardize the health and safety of the residents; nor are they of such character so as to limit our capability to render adequate care. This Plan of Correction shall also serve as the facility's written Credible Allegation of Compliance.</p> <p>F-279 A fall risk assessment was completed for resident #6 on Wednesday, 10/27/10. Resident is currently in a regular bed in the lowest position. The care plans accurately reflect the current measures. Resident #6 has not had any incidents/accidents since 06/19/10.</p> <p>The Risk Manager reviewed all Fall Risk Assessments, Incident Reports, MDS, and Care Plans for the time frame of 06/19/10 through 10/28/10 and did not identify any other residents.</p> <p>All incidents/accidents will be reviewed by the Interdisciplinary Team daily to ensure appropriate interventions are recommended, put into place and the resident's care plans are updated to reflect all changes.</p>	12-12-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Godie Jones, NHA

TITLE

Administrator

(X6) DATE

11-11-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 Set) dated July 18, 2010, revealed the resident had impaired long and short term memory, moderately impaired cognition, required extensive assistance with transfers, and had experienced a fall within the last 30 days. Medical record review of a nursing note dated June 19, 2010, at 4:50 p.m., revealed the resident was found on the floor beside the bed. Medical record review of the nursing notes and x-rays dated June 19, and 20, 2010, revealed the resident did not have any injury from the fall. Medical record review of a Resident Screen dated June 21, 2010, revealed, "PT (physical therapy) asked to screen pt (patient) p/ (after) fall. Pt had fallen out of bed. No functional change noted...Recommend mattress c/ (with) edges or 'bowl' mattress to prevent fall out of mattress/bed." Review of the facility's Post-Incident Actions after the fall dated June 19, 2010, revealed, "Pads to side of bed, PT re-screened res (resident), & convex mattress replaced regular mattress." Medical record review of the resident's care plan updated June 19, August 2, August 18, and October 11, 2010, revealed no documentation the resident was to have a convex mattress or pads to the side of the bed. Observation on October 26, 2010, at 10:55 a.m., October 26, 2010, from 8:50 a.m., until 9:05 a.m., 3:40 p.m., and October 28, 2010, at 8:05 a.m., and 8:35 a.m., revealed the resident lying in bed with the bedrails down, no pads to the side of the bed, and no convex mattress on the bed.	F 279	The corrective action will be monitored monthly in the Continuous Quality Improvement meeting comprised of the DON, ADON, Risk Manager, Medical Director, and/or Administrator for Quality Assurance.	

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F 279	Continued From page 2 Interview with CNA #1 (certified nurse aide) on October 27, 2010, at 1:15 p.m., and October 28, 2010, at 8:35 a.m., in the resident's room, confirmed the resident did not have pads to the side of the bed, the bed had a regular mattress, and the CNA was not aware of the resident ever having a convex mattress or pads to the side of the bed.	F 279		
F 281 SS=D	Interview with the risk manager on October 27, 2010, at 3:50 p.m., at the nursing station, confirmed the resident had not had any further falls and the resident was to have the convex mattress in place to prevent further accidents. Interviews with the MDS/Care Plan Coordinators on October 28, 2010, at 10:15 a.m., in the conference room, confirmed the care plan had not been updated to reflect the additional fall prevention measures. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to administer medications according to the physician's order for one resident (#6) of twenty-four residents reviewed. The findings included: Resident #6 was admitted to the facility on August 3, 2009, with diagnoses including Paranoid	F 281	F-281 On 10/27/10 the Medication Administration Record for Resident #6 was corrected to reflect the Physicians orders. The Director of Medical Records completed a Medication Administration Record audit on 10/31/10 and no other resident's were identified. There will be monthly audits for three months of all Medication Administration Records by Medical Records to check for discrepancies. The Staff Development Coordinator will conduct an in-service for all licensed staff by 12/12/2010 which will consist of training on Medication Administration Record Reconciliation and Prevention of Transcription Errors. The corrective action will be monitored monthly in the Continuous Quality Improvement meeting comprised of the DON, ADON, Risk Manager, Medical Director, and/or Administrator for Quality Assurance.	12-12-10

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F 281	<p>Continued From page 3</p> <p>Schizophrenia, Multiple Sclerosis, and Gastrostomy.</p> <p>Medical record review revealed a physician's order dated June 3, 2010, for Vitamin D 50,000 IU (International Units) to be given daily on Monday, Wednesday, and Fridays.</p> <p>Observation of a medication pass on October 27, 2010, from 8:50 a.m., until 9:05 a.m., revealed LPN #1 (Licensed Practical Nurse) was outside of the resident's room, preparing medications for administration. Continued observation revealed LPN #1 read the MAR (Medication Administration Record) for the Vitamin D to be given Monday, Wednesday, and Friday, and the area to sign the medication as given on Wednesday, October 27, 2010, had been marked with an "X" (indicating not to administer on this day).</p> <p>Medical record review of the MAR for October, 2010, revealed the medication had been administered Monday, Wednesday, and Friday, until October 13, 2010. Continued review revealed the medication was not administered Wednesday, October 13; was administered Thursday, October 14; was not administered Friday, October 15; was administered Sunday, October 17; was not administered Monday, October 18; was administered Wednesday, October 20; was not administered Friday, October 22; was administered Saturday, October 23; was not administered Monday, October 25; and was administered Tuesday, October 26.</p> <p>Interview with LPN #1 and the nursing supervisor on October 27, 2010, at 9:05 a.m., at the nursing station, confirmed the medication had not been administered according to the schedule ordered</p>	F 281		

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F 281	Continued From page 4 by the physician.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	F-323 A fall risk assessment was completed for resident #6 on 10/27/10. Resident is currently in a regular bed in the lowest position. The care plans accurately reflect the current measures. Resident #6 has not had any incidents/accidents since 06/19/10. An Occupational Therapy Screen was completed for Resident #9 on 10/18/2010. Resident is currently receiving Occupational Therapy for Range of Motion and Positioning. The care plan accurately reflects the current measures. Resident #9 has not had any incidents/accidents since 07/13/10.	12-12-10
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement fall prevention measures for two residents (#6 and #9), with a history of falls of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on August 3, 2009, with diagnoses including Paranoid Schizophrenia, Multiple Sclerosis, and Gastrostomy.</p> <p>Medical record review of the MDS (Minimum Data Set) dated July 18, 2010, revealed the resident had impaired long and short term memory, moderately impaired cognition, required extensive assistance with transfers, and had experienced a fall within the last 30 days.</p> <p>Medical record review of a nursing note dated June 19, 2010, at 4:50 p.m., revealed the resident was found on the floor beside the bed. Medical record review of the nursing notes and x-rays</p>		<p>The Risk Manager reviewed all Fall Risk Assessments, Incident Reports, MDS, and Care Plans for the time frame of 06/19/10 through 10/28/10 and no other residents were identified.</p> <p>All Incidents/accidents will be reviewed by the Interdisciplinary Team daily to ensure appropriate interventions are recommended, put into place and the resident's care plans are updated to reflect all changes.</p> <p>The corrective action will be monitored monthly in the Continuous Quality Improvement meeting comprised of the DON, ADON, Risk Manager, Medical Director, and/or Administrator for Quality Assurance.</p>	

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F 323	<p>Continued From page 5</p> <p>dated June 19, and 20, 2010, revealed the resident did not have any injury from the fall.</p> <p>Medical record review of a Resident Screen dated June 21, 2010, revealed, "PT (physical therapy) asked to screen pt (patient) p/ (after) fall. Pt had fallen out of bed. No functional change noted...Recommend mattress c/ (with) edges or 'bowl' mattress to prevent fall out of mattress/bed."</p> <p>Review of the facility's Post-Incident Actions after the fall dated June 19, 2010, revealed, "Pads to side of bed, PT re-screened res (resident), & convex mattress replaced regular mattress."</p> <p>Observation on October 26, 2010, at 10:55 a.m., October 26, 2010, from 8:50 a.m., until 9:05 a.m., 3:40 p.m., and October 28, 2010, at 8:05 a.m., and 8:35 a.m., revealed the resident lying in bed with the bedrails down, no pads to the side of the bed, and no convex mattress on the bed.</p> <p>Interview with CNA #1 (certified nurse aide) on October 27, 2010, at 1:15 p.m., and October 28, 2010, at 8:35 a.m., in the resident's room, confirmed the resident did not have pads to the side of the bed, the bed had a regular mattress, and the CNA was not aware of the resident ever having a convex mattress or pads to the side of the bed.</p> <p>Interview with the nursing supervisor on October 27, 2010, at 3:45 p.m., at the nursing station, confirmed the resident did not have the convex mattress in place and a convex mattress had not been ordered for the resident.</p> <p>Interview with the risk manager on October 27,</p>	F 323		

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F 323	<p>Continued From page 6</p> <p>2010, at 3:50 p.m., at the nursing station, confirmed the resident had not had any further falls and the resident was to have the convex mattress in place to prevent further falls:</p> <p>Resident #9 was re-admitted to the facility on October 28, 2010, with diagnoses including Failure to Thrive, Abnormal Involuntary Movement, Malaise and Fatigue, and History of Fall.</p> <p>Medical record review of the MDS dated September 29, 2010, revealed the resident had impaired long and short term memory, moderately impaired cognition, required extensive assistance with transfers, and had experienced a fall within the last 30 days.</p> <p>Medical record review of a nurse's note dated September 5, 2010, at 9:20 a.m., revealed, "Resident (up) in broda chair. Noted body alarm activated & resident lying in the floor on (L) (left) side. Resident verbalized...slid out of chair into floor. Denies any discomfort..." and no injury was documented.</p> <p>Medical record review of the Rehab Supplemental Screening of Resident Falls revealed, "...Screen date 9/7/10. Fall date 9/5/10...Pt attempted to get out of Broda chair & slid to floor...confused; poor safety...OT (occupational therapy) to screen..."</p> <p>Medical record review revealed the only therapy screens completed in the medical record had been a quarterly screen completed August 24, 2010, and a screen due to decreased range of motion completed October 18, 2010.</p> <p>Interviews with the risk manager on October 28,</p>	F 323			

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F 323	Continued From page 7 2010, at 9:30 a.m., at the nursing station, and with the manager of therapy on October 28, 2010, at 9:45 a.m., in the therapy department, confirmed the resident had not had any further falls; the resident was to have an occupational therapy screen after the fall on September 5, 2010, to determine if any further fall interventions were needed; and the screen had not been completed.	F 323			
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to obtain a Depakote level for one resident (#11) of twenty-four residents reviewed. The findings included: Resident #11 was admitted to the facility on February 16, 2001, with diagnoses including Fractured Femur, Osteoporosis, Dysthymic Disorder, Peripheral Vascular Disease, and Cerebrovascular Accident. Medical record review of the physician orders dated January 2010 through October 2010 revealed "...Depakote Level January/April/July/October..." Medical record review of the laboratory data revealed no Depakote lab results for July 2010.	F 502	F-502 The Depakote level for resident #11 was obtained 10/28/10. The results were reviewed by the Nurse Practitioner on 10/29/10 with no new orders. The Medical Records Director conducted a complete audit of routine labs and no other residents were identified. The Medical Records Director will complete a weekly audit for three months on all lab orders to ensure all labs are scheduled and completed timely. Results of audits will be reviewed during the weekly Focus meeting. The corrective action will be monitored monthly in the Continuous Quality Improvement meeting comprised of the DON, ADON, Risk Manager, Medical Director, and/or Administrator for Quality Assurance.		12-12-10

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A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
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10/28/2010

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DEFICIENCY)(X5)
COMPLETION
DATE

F 502

Continued From page 8

F 502

Interview with the Director of Nursing, on October 27, 2010, at 1:55 p.m., and 3:00 p.m., at the East nursing station and lobby, confirmed the

F 514
SS=D

Depakote level was ordered to be obtained in January, April, July, and October. Further interview confirmed the July 2010 Depakote results were not in the medical record. Further interview confirmed the lab log did not contain information to obtain the routinely ordered Depakote level in July 2010. Continued interview confirmed the facility failed obtain Depakote level as ordered by the physician for the month of July 2010.

483.75(l)(1) RES
RECORDS-COMplete/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, and interview, the facility failed to ensure accurate and complete documentation in the medical record for two residents (#12, #16) of twenty-four residents reviewed.

F-514

F 514

Wound documentation for resident #16 was updated to identify the location, measurements, and drainage to include; type of drainage, amount of drainage, any odors, status of the wound bed, or the periwound tissue. Wound documentation for resident #12 was updated to reflect location, measurements and drainage to include type of drainage, amount of drainage, any odors, status of the wound bed, or the periwound tissue.

The Director of Nursing and the Treatment Nurse reviewed all residents with current wound care protocols and no other residents were identified.

Documentation for residents with wounds will be reviewed weekly during the Focus meeting.

The corrective action will be monitored monthly in the Continuous Quality Improvement meeting comprised of the DON, ADON, Risk Manager, Medical Director, and/or Administrator for Quality Assurance.

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F 514	<p>Continued From page 9</p> <p>The findings included:</p> <p>Resident #12 was admitted to the facility on March 5, 2009, and readmitted on June 8, 2009, with diagnoses including Hypertension, Sepsis, Down's Syndrome, Alzheimers Disease, Chronic Decubiti, Left Eye Blindness, Cerebrovascular Accident, and Myoclonus. Medical record review of the Minimum Data Set (MDS) dated August 8, 2010, revealed the resident required total care for Activities of Daily Living (ADLs), had been incontinent of bowel, had a Foley catheter, on a puree diet with thickened liquids, severely impaired cognitively; and had a Stage III pressure ulcer.</p> <p>Medical record review of a Treatment Record dated October 18, 2010, revealed the resident had a Stage IV pressure ulcer on the right hip, measuring 1 cm (centimeter) x 2.2 cm x 0.9 cm. Continued medical record review of the Treatment Record revealed "Medium amount of drainage coming from wound." Further medical record review dated October 25, 2010, revealed "Stage IV 1 x 2 x 0.9 rt. (right) hip. Medium amount of drainage." Medical record review revealed no documentation of the type of drainage, any odors, status of the wound bed, or the periwound tissue.</p> <p>Resident #16 was admitted to the facility on September 24, 2010, with diagnoses including Prostate Cancer, Colostomy, Removal of Rectum, Chronic Obstructive Pulmonary Disease, Hypertension, Obstructive Sleep Apnea, and Left Tibia Fracture. Medical record review of the MDS dated October 1, 2010, revealed the resident was cognitively intact, required extensive assistance</p>	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELMHURST DR OAK RIDGE, TN 37830		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 514	<p>Continued From page 10</p> <p>with ADLs, had a Foley catheter in place, was continent of bowel, and had no ulcers present on admission.</p> <p>Medical record review of a note by the Risk Manager dated October 13, 2010, revealed "Hip to foot left leg brace. When removed burst blister discovered on top of left foot." Review of a 72-Hour Incident Documentation form revealed "Brace has rubbed blister to left foot - planter side of foot - busted - skin intact with no surrounding redness or edema. No drainage."</p> <p>Medical record review of a Treatment Record dated October 25, 2010, revealed "2 cm x 2 cm Stage III on ankle. Left lateral 1 cm x 0.5 Stage III. See new order." Medical record review of a physician's order dated October 25, 2010, revealed "Clean wound (L) lateral ankle with wound cleanser; apply skin prep to periwound; apply Aquacel to open area only; secure with gauze." Continued medical record review revealed no documentation of any drainage from the two ulcers, the appearance of the wound beds or periwound areas; and incomplete documentation as to which ulcer is being measured and its location.</p> <p>Review of the facility policy entitled "Pressure Ulcer Prevention Guide" revealed weekly documentation of characteristics of normal skin and characteristics of tissue deformation."</p> <p>Interview with the Director of Nursing on October 28, 2010, at 12:35 p.m., in the Administrator's Office, confirmed the documentation of the pressure ulcers was not complete regarding the type of drainage or status of the wound bed and periwound tissue for resident #12 and #16.</p>	F 514			

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(X5)
COMPLETION
DATE